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SUBMITTED TO THE
APPROPRIATIONS COMMITTEE
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HB 5044, An Act Making Adjustments To State Expenditures For The Fiscal Year Ending June 30, 2017

As the chairman of the Department of Psychiatry for Danbury Hospital and New Milford Hospital, I appreciate the opportunity to submit testimony concerning **HB 5044, An Act Making Adjustments To State Expenditures For The Fiscal Year Ending June 30, 2017**. We oppose the imposition of budget cuts for mental health and substance abuse disorder treatment services. At a time when health care is transitioning from a fee for service payment model to a value based payment model these cuts will ultimately cost the state millions of dollars in unnecessary health care expenses by driving the under and uninsured back to emergency departments and hospitals where the cost of care is greatest.

A recent article in the New England Journal of Medicine outlined that when comparing high utilizers of health care resources, there were clear distinctions by diagnosis between Medicare, the privately insured, and Medicaid patients. It found that, unlike high utilizers with Medicare and private insurance, high utilizers with Medicaid consume most of their resources in the area of mental health. (1) Thus, if one is going to reduce the cost and improve the care for all Medicaid beneficiaries, it is critical to focus on these high utilizers and support efforts to steer them toward outpatient services and reduce their utilization of emergency department and hospital based services. This requires an investment in the growth of access to outpatient mental health services.

There are three main institutions providing outpatient mental health services to the Medicaid population: 1) State supported outpatient clinics; 2) Private Non-Profit institutions (PNPs), and 3) Hospital based outpatient programs. Many believe that most outpatient mental health services are provided by either state clinics or PNPs so any cuts to hospitals would not impact those services. But the PNPs also face severe budgetary constraints by these cuts, and thus access to them will be further reduced. Finally, state operated outpatient clinics do not depend on Medicaid revenue, are under no mandate to improve access, and many are effectively closed to new patients.

At Danbury and New Milford Hospitals where I work, the state supported local mental health center serves less than 200 patients, and is closed to all but the most chronically ill. Additionally we have no PNP so we are the only option. The DMHAS grant money we receive supports the added expense – but not the full expense - of caring for these patients as Medicaid does not cover their entire cost of care. The grant calls upon Danbury and New Milford to cover at least 630 patients but we routinely cover 850 patients in addition to the more than 2000 patients in our system with mental health and substance abuse needs. The DMHAS grant funding is needed to ensure that these hospital based outpatient mental health services can continue to provide care for this population in as close to a cost-neutral basis as possible. These DMHAS grant cuts will only compound the continued Medicaid cuts to our hospitals, furthering the diminished access to mental health services for the Medicaid population. Finally, the Governor is recommending cutting the funding to community care teams, which have been largely organized by hospitals and target high Medicaid utilizers as noted in the NEJM article, even though these teams have amply demonstrated their ability to save the state tens of millions of dollars going forward.

All of these cuts conspire together to target patients with mental health problems. Outpatient centers who cannot afford to provide mental health services will have no alternative but to cut them which will limit access. Hospitals that have no such alternative to escape the state will see an increase in patients seeking mental health care in their EDs and these patients will present sicker, need higher cost services including hospitalization, and when stabilized, will have no safe discharge plans. This scenario delays their discharge and further drives up the cost of care. This happened in Sacramento, CA after their academic medical center cut its psychiatric beds in half and closed its outpatient facility. In 8 months the number of psychiatric emergency department visits tripled and length of stay increased 33%. The number of violent events increased more than 5 fold and those presenting with psychosis increased 400 %. (2)

Connecticut was one of the first states in the nation to embrace the affordable care act and expand the Medicaid rolls to its population. This took vision and courage and our hospitals were big proponents of this change. The governor has told its citizens how proud he is for making Medicaid available to more people, but then has systematically cut Medicaid payments to the very institutions whose mission it is to provide care to those we are collectively tasked with serving. By doing so he has jeopardized those institutions ability to provide needed care, and placed the Affordable Care Act in jeopardy of realizing its goals of providing high quality, cost effective care to its citizens. More simply, he is putting people and communities at risk.

I appreciate this opportunity to be heard and hope you will give my comments every consideration.

1. Powers and Chaguturu. “ACOs and High-Cost Patients”; New England Journal of Medicine 2016; 374;3: 203-5
2. Nesper et al. “Effect of Decreasing County Mental Health Services on the Emergency Department; Annals of Emergency Medicine, on line and in press, November 13 2015; http://www.sciencedirect.com/science/article/pii/S0196064415012706